Social inclusion or social control?
Homelessness and mental health

Theodore Stickley and colleagues examine the contradictory nature of mental health policy in the UK: one which seeks both to promote social inclusion and recovery, and yet extend social control through a coercive agenda.

In the UK a new and refreshing literature is emerging that addresses the need for socially inclusive models and strategies for people with mental health problems (e.g. Bates 2002a, Repper and Perkins 2003). There appears, however, to be little evidence for strategies that are specifically aimed at people who endure the dual problem of homelessness and mental ill health. Last year, the government published its report on mental health and social exclusion (Social Exclusion Unit 2004). Here we offer some background to current policy and legislation that may be useful to those working with people who are homeless and experience mental health problems; we also examine the potential of social inclusion for this group of people and critique strategies for inclusion in the light of current policy.

For some people, homelessness is a direct consequence of housing policies; for example, former legislation excluded single people and childless couples from full legal protection. It is only now that these groups are being prioritised in the Homelessness Act 2002 as it gives far more protection to the homeless than before by extending the provisions to 16 and 17 year olds, to young people coming out of care institutions, and requiring councils to produce preventive strategies (Malcolm 2002). This legislation seeks to draw together social services, health workers, home providers and voluntary organisations to find the most effective response to local need, and work with them to implement and review the housing strategy.

A national problem
Homelessness is a national problem in the UK with the government estimating that 600 people sleep on the streets (Crisis 2003, Department for Transport, Local Government and the Regions 2002). This figure may be an under-estimate because of confusion over the definition of what constitutes homelessness and the difficulty in measuring the numbers accurately. The actual total number of people who are genuinely homeless is extremely hard to ascertain as it can include people in temporary accommodation. The number may well run into hundreds of thousands (Crisis 2003, Shelter 2003), although it is unclear how these organisations reach their figures.

There is a special problem of homelessness among young people (SEU 1998) with no accurate figures available for the number of single young homeless people. It is estimated that from 50-60 per cent of homeless people experience mental health problems (Crisis 2003, Shelter 2000). It is thought that 88 per cent of these experienced their problems prior to becoming homeless (Randall and Brown 1999). Mental health workers need to know how to engage with this client group successfully, as they present challenges to workers that require specialist understanding and intervention.

While acknowledging the need for strategic assertive outreach to this client group, this is not the focus of this paper. Instead, we discuss what social inclusion might mean for this group and consider some of the political implications for policy makers.

Much of the original literature relating to homelessness and mental health focuses on the effects of the closure of the asylums in the UK. The introduction of community care resulted in a greater degree of freedom over treatment. However, it subsequently failed to facilitate greater community integration (Bates 2002a). Pilgrim and Waldron (1998) have suggested that the move from the old institutions to the community has been incomplete, and has resulted in a continuing emphasis on buildings and professional practice, something they call ‘re-institutionalisation’.

Many individuals have chosen to disengage from this option of a lifestyle. Therefore, although community care appeared to carry the potential for people with mental health problems to be integrated in mainstream society, it is argued they metaphorically remain as firmly excluded today as they ever were behind the walls of the asylum (Repper and Perkins 2003). Furthermore, it is time to re-evaluate these arguments in the light of demographic changes in the homeless population. We can no longer blame asylum closure for the large numbers of homeless people, as many of them are young and there are factors other than de-institutionalisation which have contributed to their current circumstances (Warnes and Crane 2000). That said, the closure of the asylums may have triggered the escalation of many current social problems.

Reasons for homelessness
The question of why people become homeless is frequently asked; the reasons are complex, wide ranging and multifactorial (Fitzpatrick et al 2000). Underlying and predisposing factors may include: poverty, experience of the care system through childhood, family breakdown, mental health problems and triggers often include; loss of job and mental breakdown.

Homelessness, for many, is a process rather than the result of a single event, although recent research indicates that relationship breakdown accounts for much homelessness...
loss of support and greater isolation, further entrenching the detached from society. Unconventional behaviour leads to a mainstream community may not feel the need to behave in a conventional manner and will inevitably become more mainstream. The relationship between mental ill health and social behaviour is central to social acceptance; people with few or no ties to mainstream society is liable to deteriorate or breakdown. The individual may become distrustful of others and enter a role of learned helplessness.

Often seen as dirty, hopeless scroungers, homeless people become objects of avoidance, which may confirm and intensify the individual's feelings of mistrust and compound the need for further withdrawal and isolation (Goodman et al 1991). Porter (1997) argues that anyone without a mental health problem prior to the experience of homelessness, is more than likely to develop serious mental distress while homeless. Furthermore, suicide accounts for one in four deaths among those who are homeless (Mental Health Foundation 1997). The psychological damage brought about by social exclusion has yet to be measured (Bates 2002a), and social ties are essential to psychological health (Cohen and McKay 1984).

**Homelessness and society**

The relationship between mental ill health and social behaviour is central to social acceptance; people with few or no ties to mainstream community may not feel the need to behave in a conventional manner and will inevitably become more detached from society. Unconventional behaviour leads to a loss of support and greater isolation, further entrenching the cycle of homelessness (Grigsby et al 1990). In some instances, homeless people do belong to a community of sorts. This is part of the problem, in that the fellowship between street people may become the only community they can trust. Homeless people report a greater sense of being apart from the world. This experience parallels the phenomena of psychosis, a sense of detachment and loss of reality (Goodman et al 1991). The high prevalence of psychosis among people who are homeless is clearly related to this detached state of social being. It is argued further that the homeless person, once identified as such, embarks on a moral career, which affects the very core of their self-identity. The social reaction to their different behaviour can be so extreme as to rob them of their selfhood, and, as such, they may be institutionalised according to the demands and regulations of society (Zola 1972).

Scheff (1966) attempted to identify what it was about certain types of behaviour that made them susceptible to social labelling. He argued that unreasonable conduct in everyday situations was particularly threatening to social order as it broke some of the residual rules of social life and termed this concept as ‘deviance’. He suggested that the stereotyped imagery of mental disorder is learned in early childhood and continually reinforced through both media and everyday social interactions. The implications of this are that individuals who have been labelled as deviants may be rewarded for playing the stereotyped deviant role. They may interpret their own personal experiences in light of the label and even modify their behaviour to fit the image. Therefore labelled deviants are punished when they attempt to return to conventional roles.

This stigmatisation extends into the spheres of employment, interpersonal relationships and the wider social world (Hannigan 1999). Recently, homeless people with mental health problems have been labelled people with ‘multiple needs’ (Homeless Link 2002). While this label may be a helpful reminder that homeless people’s problems are more than simply housing, we should caution against creating ‘catch all’ categories. Mental health is itself a hugely contested concept and poverty itself is a mental health problem (Seedhouse 2003).

The state of becoming homeless, is, in itself, perhaps one of the most devastating traumas an individual can experience. The psychological effects cannot be underestimated. The trauma can effectively drive a person into a state of helplessness. When compounded with the experiences and labelling of schizophrenia, the person’s ability to cope with the trauma is severely diminished (Porter 1997). One feature
of the psychology of people who are homeless may be the felt need to reject those who are perceived to offer help, particularly help from the statutory sector who are often seen as ‘in authority’. This presents a very real challenge to workers who seek to build therapeutic relationships as there is an increased need for unconditional acceptance. It is possible for homeless people to develop a fatalistic attitude towards their problems and this perceived lack of control at times may lead the individual to refuse services as a way of regaining a sense of personal control (Corrigan et al 1990). Consequently it is only when mental health practitioners believe in the rights and abilities of those who use their service that they can positively promote and achieve social inclusion.

Mental health practitioners need to treat individuals with respect and dignity in order for them to rebuild these qualities within themselves. Repper and Perkins (2003) state that practitioners have to be able to trust individuals as able and competent, rather than passive recipients of care, and build with their client a hope inspiring relationship in which the service user is able to believe in his or her own abilities and rights. The essence of socially inclusive practice is to enable the person to rebuild a life that is valuable and meaningful to him or her, therefore it is important to explore the individual's ambitions. The practitioner’s role within the process of promoting inclusion is to help people see what is available and then support the individual to explore his or her options.

It is important for the practitioner therefore to demonstrate their confidence in the individual as the social impact of mental health problems and homelessness may have left the person doubting their abilities (Dunn 1999). Foucault (1967) argues, madness is treated and constructed in line with the preoccupations of the age. The way in which madness is constructed determines the values attached to those deemed ‘mad’ and the options available to them. The biomedical model of care is still dominant in western psychiatry today, which leads to the question: what hope is there for social inclusion when the social aspect of mental distress is neglected or ignored? (Dunn 1999).

Perkins and Repper (2001) recognise that as long as the emphasis of services and professionals lies in the eradication of symptoms, then the views and wishes of people who have these symptoms will be disregarded. Thus, despite the evidence that service users prioritise help with housing, employment, social contacts and practical tasks, service providers continue to prioritise therapy and use of statutory services (Dunn 1999).

Homelessness and social exclusion

In June 2004 the government’s Social Exclusion Unit (SEU 2004) produced its Mental Health and Social Exclusion report. In the foreword the prime minister states that the report came about because the government asked: ‘How could we better attack the cycle of deprivation linked to mental health?’ Solutions to problems of homelessness therefore might well have been expected.

On the surface this report should be welcomed because of its 27-point action plan; however, this document needs to be seen in the context of other government initiatives that relate to people who are homeless and with multiple needs. For example, the government is determined to eradicate ‘anti-social behaviour’ (Department of Health (DH) 2003). It is clear from this document (Respect and Responsibility – Taking a Stand Against Anti-Social Behaviour) that homeless people are included in those targeted. What we are left to decide is whether the government’s agenda is to genuinely help homeless people with mental health problems or is it more a question of cleaning up the streets? This is captured in the following quote from Campbell (1997), a service user and respected voice within current the user/survivor field.

‘Continually returning to the long-standing negative perceptions about mad persons must jeopardise the chances of meaningful inclusion, even if you add at the end that only a small percentage actually fulfil the stereotype. Social inclusion needs to be based on a positive vision, a belief that the newly-included will bring something valuable, not that if we watch them closely enough then they probably won’t mess up.’

In trouble with the law

It is already a fact that homeless people are far more likely to come into contact with the police than social services (Crisis 2003). When it comes to mental health policy, the government presents contradictory messages. On the one hand it promotes recovery and social inclusion; notably through 'The Journey to Recovery – the Government’s Vision for Mental Health Care’ (DH 2001); and Mental Health and Social Exclusion (SEU 2004). Similarly, the DH has launched an excellent mental health promotion initiative (Mindout.net 2003) tackling stigma and discrimination. These positive initiatives are against a backdrop of proposed mental health legislation exemplified by the draft Mental Health Bill that is far more about coercion than recovery and social inclusion.

Additionally, it is widely argued that the draft Bill will have the effect of increasing stigma and discrimination because of the powerful negative implication of the dangerousness of the mentally ill inherent in the ethos of the proposed bill. What excluded people want is no different to what anybody else wants: somewhere decent to live, something meaningful to do and relationships (Dunn 1999). While mental health policy seeks to control people through coercion and treatment, it is understandable that people might prefer to remain excluded if inclusion implies having forced treatment. The rhetoric of today’s social inclusion agenda may well become the cover for tomorrow’s social control. Campbell (1999), questions on what basis inclusion is being offered to people with a psychiatric diagnosis. And to what extent do these individuals remain a special group in society, whose full participation is conditional on particular behaviour.

The social exclusion of people with mental health problems is also of interest to policy makers for economic and public health reasons. Mental ill health accounts for 10.5 per cent of the total global burden of disease and is expected to rise to 15 per cent by the year 2020 (Jenkins 1997). This percentage represents a large sector of the global population who are often economically inactive. The government is concerned with increasing productivity among people with identified disabilities and in doing so, reducing the cost of disability benefits (Sayce 2000). However, service users have expressed the need to avoid simplistic definitions of what ‘productivity’ actually is. Furthermore, they felt that the consequences of distorted value systems, of seeing people only as economic benefits or deficits, contributes to an erosion of the concept of mutual support with communities (Dunn 1999).

While the SEU report talks about issues of employment and access to health services, the reality of being homeless and experiencing mental health problems is extremely complex; for as long as services appear threatening, homelessness among the mentally ill will remain a major issue. Policy initiatives that focus on coercion and control draw the attention away from the real social issues. While services focus on lack of engagement of the individual, statutory services are exonerated from the responsibility of addressing the wider social issues.
of stigma, discrimination and the damning consequences of negative media portrayal of the mentally ill.

Similarly, for many people, the lifestyle of homelessness may represent a choice of non-conformity and opting out of the system. For many, engagement with services implies conformity to white middle-class values, with all of its systemic demands. Access to appropriate health care is further exacerbated by rejection at GP surgeries – partly due to stigma and also to the fact that GPs receive no payment for people using their practice for fewer than three months – the SEU report however highlights that following new General Medical Services contracts, GPs can offer specialist mental health assessments for homeless people. Critically, this needs to extend to all health needs of the homeless person if the government is committed to inclusive healthcare provision.

The emerging contemporary mental health policy also has implications for the role of the mental health worker who aims to promote social inclusion for this client group. Campbell (1997) states that users of mental health services value interpersonal relationships with mental health workers highly and want them to work alongside them as oppose to contain and ‘fix’ them. However the dilemma facing these workers is their contrasting role of enforcing ‘social control’ (Szasz 1974). The proposed mental health policy appears to move towards a more controlling and coercive policy framework, which is likely to alter the delicate balance in mental health practice further away from the provision of ‘care’ and more towards ‘control’ (Hannigan and Cutcliffe 2002). This is a direct contradiction to working within a socially inclusive framework of practice, as it would involve the further disempowerment and segregation as opposed to facilitation of choice and promotion of inclusion.

Society currently faces a choice: to address the complex social issues that perpetuate homelessness or to implement coercive and controlling policies that appear to address the problems (by ‘cleaning up the streets’). In 1998, Paul Boateng, junior health minister, informed us:

'We have got to build a new basis of confidence in our mental health services. The public is entitled to nothing less. This means making sure that every existing mental health hospital closure is backed up by a tough and credible alternative package which includes a mix of new style hospital care and community provision’ (Boateng 1998).

New mini asylums

The old style asylums may not be attractive to the public, however, new discrete asylums may well be. Without a ‘joined up’ inclusion strategy it is inevitable, judging by current policy initiatives, that this ‘underclass’ (Hills et al 2002) will become re-housed in mini asylums, thus completing the circle (see Figure 1).

A practical alternative to the mini asylum approach is the development of ‘core and cluster’ supported tenancy housing schemes making use of new flexibilities created through the Supporting People agenda. This model of community care enables services to collaboratively work towards a more socially inclusive housing provision that also provides the right and proper statutory care element, an example of this model is offered elsewhere (Stickley and Leng 2003).

It is only by seeing today’s homeless people with mental health problems in the context of social history, that we can begin to contemplate a successful inclusion agenda for this group of people. What has happened in the UK in the last 20 years could never have been anticipated. Community care promised so much but delivered so little (Repper and Perkins 2003). While successive governments saved millions of pounds in mental health inpatient care, the subsequent social problems will inevitably cost vast sums to put right. The government’s coercive agenda however may find sympathy with the voting public who wish to be protected from the ‘axe-wielding madman’ so often portrayed in the media. This same public may prefer tax payers’ money to be used in protection rather than investment in solving the problems of homelessness.

Furthermore, it is argued within the service user literature that the position of people with a mental illness diagnosis in contemporary British society is not just to do with mass media exploitation of madness and violence, but is also a result of an accumulation of messages, attitudes and disempowering practices that have emanated from health and social care professionals over a long period. Campbell (1999) maintains that society is learning from mental health workers; therefore it is not enough to wait for policy and public attitudes to change. Individual mental health workers may not be able to change the world, but their attitudes and practices can influence the opportunities of individuals with whom they work (Repper and Perkins 2003).

Homelessness and the social inclusion agenda

To facilitate the successful transition from homelessness to fully housed, workers need to give careful thought to the support people might need. Many people might not be able to cope with independent accommodation and thought has to be given to the high level of support some might require in order to succeed (Warnes and Crane 2000). Most breakdowns in tenancy among the homeless who have been housed occur shortly after support has been withdrawn from mental health teams (Craig 1995). Workers also need to be prepared for continued behaviour associated with homelessness as it is quite possible for people to continue their homeless lifestyle even when living in new accommodation (Crane 1999).

The reason perhaps much of the social inclusion literature provides no blueprint for the problems of homeless people is because there is no easy and quick-fix answer. For strategies of inclusion to be successful for this group of people, there needs to be a development and implementation of policies that address the underlying issues:

- legislation that prohibits any form of discrimination against people with mental health problems.
- While addressing issues of access to work and education, this need to go further than the Disability Discrimination Act to address
stigmatising attitudes, e.g. media portrayal.

- development of an educational strategy for all primary care staff to promote inclusive approaches towards people that are homeless.
- development of primary care services that reaches out to this group without the expectation that people must engage with statutory psychiatric services.
- the provision of appropriate, accessible and decent housing with appropriate service support, e.g. partnership projects between housing and services in core and cluster models of housing and care.
- the provision of accessible methods for homeless people to receive state benefits.

Conclusion

The phenomenon of homelessness in contemporary western society throws up many challenges for healthcare workers. Social inclusion for homeless people is more than simply providing adequate housing. Homelessness is a result of complex social issues and the victims are invariably those affected by family and social trauma. Mental ill health among the homeless is understandable, with 60 per cent depressed and 36 per cent suicidal (Branigan 2002). The efficacy of working with homeless people who experience mental health problems is determined not only by social and economic policy, but also the quality of the individual relationship. The literature identifies that mental health services and those individuals working in them have the potential to facilitate inclusion for this client group (Repper and Perkins 2003) due to their power to initiate a potential inclusive opportunity and give reassurance to the person directly (Bates 2002b).

However, evidence suggests service users themselves perceive many aspects of mental health services as contributing to the problem of exclusion (Dunn 1999), as a result of an accumulation of messages, attitudes and disempowering practices that have emanated from health and social care over a long period (Campbell 1999).

Strategies to promote social inclusion need to be about helping people to access mainstream social resources without enforcing required conformity to societal norms. Scull (1979) states the promotion of conformity can be observed within the role of mental health practitioners throughout history. It is argued by Scheff (1966) that the route of this concept lies predominantly in the professional’s aim to define deviance from social norms as illness, disorder or disease. Reissman (1992) describes this process of medicalisation of emotional reaction as involving interrelated processes: first, certain behaviours or conditions are given medical meaning that is defined in terms of health or illness; second, medical practice becomes a vehicle for eliminating and controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms. Through these processes medicine becomes not merely a scientific enterprise but a social one because of its mandate to control social deviance and social risk. This position that equates mental health with conformity to a particular set of beliefs becomes a moral issue in which judgments are made, not in the name of virtue or legitimacy, but in the name of health (Zola 1972). Most importantly, inclusive strategies can only be expected to work with social and economic policies that tackle poverty and facilitates access to employment and education for those on the fringes of society.

References


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